



KENTUCKY BOARD OF CHIROPRACTIC EXAMINERS

P.O. BOX 183
Glasgow, Kentucky 42142-0183
Phone (270) 651-2522 Fax (270) 651-8784
e-mail <kychiro@glasgow-ky.com>

Authorization for Release of Medical and Chiropractic Records to the Kentucky Board of Chiropractic Examiners

I, _____, the undersigned, hereby authorize the full release of any and
Print full name of patient

all medical records, billing information and medical reports from the chiropractor, physician, or other
medical personnel, or any licensed health care facility regarding the medical history, diagnosis and treat-
ment relevant to my initiating complaint, filed against _____ ,
Name of treating Chiropractor

to the Kentucky Board of Chiropractic Examiners, or any authorized agent or investigator of the Board.
The Board's address is: P.O. Box 183, Glasgow, KY 42142-0183. Copies of such documents may be
mailed to the Board at this address or hand-delivered to any authorized agent or investigator of the Board.
A photocopy of this authorization shall be deemed as effective as an original. This authorization shall be
effective for one year from the date of signing.

Date

Signature of patient or legal guardian of patient